31-008.05B Total Inpatient Days: In computing the provider's allowable cost per day for determination of the prospective rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days. Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document,") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.05C New Construction, Reopenings, and Certification Changes: For new construction (entire facility or bed additions), facility reopenings, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering NMAP after July 31, 1982, shall capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first client (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: An ICF/MR's prospective payment for ICF/MR services shall not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge. The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding). The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, times a percent equal to 1 1/2 times the Inflation Factor (see 471 NAC 31-008.06C5) for the most recent report period. Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that –

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with others than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions; and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

31-008.05G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-009.05J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will –

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the Department of Health and Human Services (HHS), or their designated representatives.

31-008.05H Interest Expense: For rate periods beginning January 1, 1985, interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for long term care. This limitation does not apply to government owned facilities.

31-008.05J Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions shall be the lesser of –

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Department of Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 31-008.07D, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, et seq., the fixed costs reported to the Department of Social Services for a Department of Health Certificate of Need reviewed project shall not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department of Social Services, for the purposes of rate setting, shall be the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Department of Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Department of Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Department of Health Division of Hospital and Medical Care Facilities. The added costs incurred prior to the date the late amendment or report is filed will not be recognized retroactively for rate setting.

31-008.05L Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the Department of Health and Human Services. All compensation received by an Administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Nebraska Department of Personnel in the "State of Nebraska Salary Survey".

31-008.05M Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.

31-008.05N Facility Bed Size: To qualify for rate determination under provisions of 31-008 ff., the facility shall have a minimum of 15 licensed beds. Facilities with fewer than 15 licensed beds on October 1, 2000 shall be grandfathered into this methodology; facilities with fewer than 15 licensed beds after October 1, 2000 shall be reimbursed under provisions of the Nebraska Home and Community Based Waiver Program.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The rate period for non-State operated facilities covers services provided January 1 through December 31 of each year. A Rate Period may be identified as either a Rebase Year or an Interim Year.

31-008.06A1 Rebase Year: A Rebase Year occurs January 1, 2001, and every third year thereafter, i.e., January 1, 2004, January 1, 2007, etc.

31-008.06A2 Interim Year: An Interim Year is every year that is not a Rebase Year.

31-008.06B Reporting Period: Each facility shall file a cost report each year for the twelve-month reporting period of July 1 through June 30 of each year.

31-008.06C Rates for Rebase Years for Intermediate Care Facility for the Mentally Retarded (ICF/MRs) Excluding State-Operated ICF/MRs: Effective January 1, 2001, subject to the allowable, unallowable, and limitation provisions of this system, the Department pays each facility a prospectively determined amount for reasonable and adequate costs during each rate period. The per diem rates are based on financial and statistical data from the most recent cost report period, submitted by the facilities. Individual facility prospective rates have four components:

1. The ICF/MR Personnel Operating Cost Component;
2. The ICF/MR Non-Personnel Operating Cost Component;
3. The ICF/MR Fixed Cost Component;
4. The ICF/MR Ancillary Cost Component; and
5. The Inflation Factor.

An ICF/MR facility's prospective rate is the sum of the above five components, subject to the rate limitation provisions of this system.

31-008.06C1 ICF/MR Personnel Operating Cost Component: This component of the prospective rate includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion of the personnel operating cost component shall consist of direct care staff, direct care administration, active treatment, and medical services. The support services portion shall consist of dietary, laundry and housekeeping, property and plant, and administrative services.

Both the resident care services and the support services portions of the personnel operating cost component of the prospective rate are the lower of –

1. The allowable personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by 1 1/2 times the Inflation Factor computed under provisions of 471 NAC 31-008.06C5, or
2. The facility's Personnel Operating Cost Model, adjusted by 1 1/2 times the Inflation Factor computed under provisions of 471 NAC 31-008.06C5.

31-008.06C1a Personnel Operating Cost Model: The personnel operating cost model cost per day for each facility is determined based on each facility's average actual occupancy per day limited to an average occupancy of not less than 15 residents per day, level of care resident mix, staffing standards, and reasonable wage rates as adjusted for reasonable fringe benefits.

31-008.06C1a(1) Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in item (3), are used to determine each facility's efficient and adequate personnel cost. The 19 staff categories and respective standards are used to determine total efficient and adequate personnel cost and are not intended to be required staffing levels for each staff category. All standard hours per resident day are paid hours and, therefore, include vacation, sick leave, and holiday time.

The staff categories and standards are as follows:

Staff Categories	Hours per Resident Day All
Direct Care Staff -Aides, attendants, houseparents, counselors, house managers	6.5160
Direct Care Admin. -QMRPs, residential service/ program coordinators, direct care supervisors	0.9105

Active Treatment Services	Hours per Resident Day All
-Physical therapists & assistants	0.0620
-Occupational therapists & assistants	0.0830
-Psychologists	0.0940
-Speech therapists & audiologists	0.0700
-Social workers	0.1390
-Recreation therapists	0.1460
-Other professional & technical staff	0.4330

Medical Services	
-Health services supervisor	--------see description following---------
-Registered nurses	--------see description following---------
-LPN or vocational nurses	0.1975
Dietary	
-Dietitian, nutritionists	0.0230
-Food service staff	0.5540
Laundry & Housekeeping	
-Laundry & housekeeping personnel	0.3940
Property & Plant	
-Maintenance personnel	0.3000
Administration	
-Administrator	--------see description following---------
-Assistant administrators	--------see description following---------
-Other support personnel	--------see description following---------

The standard for the Health Services Supervisor position is one full-time equivalent employee, which will result in a varying number of standard hours per resident day depending upon the number of resident days. The standard hours per resident day for registered nurses are 0.1885 reduced by the Health Services Supervisor hours per resident day. However, these standard hours may not reduce the facility below one full-time equivalent for the combined Health Services Supervisor and R.N. positions.

The standard for the Administrator position is one full-time equivalent employee. The standard for assistant administrators is based on facility size and is as follows:

Number of Residents	Number of Assistant Administrators
1 to 100	None
101 to 200	1
201 to 300	2
301 to 400	3
401 to 500	4
501 and over	5

For other support personnel, the standard hours per resident day are 0.608, reduced by the assistant administrators' hours per resident day.

31-008.06C1a Standard Wage Rates: Wage rates for each personnel category will be determined annually based on the actual average wage rates of the Beatrice State Developmental Center for the current cost report period.

31-008.06C2 ICF/MR Non-Personnel Operating Cost Component: This component of the prospective rate includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The non-personnel operating cost component of the prospective rate is the lower of –

1. The allowable non-personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by a percentage equal to 1 1/2 times the Inflation Factor computed under provisions of 471 NAC 31-008.06C5;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/MR facilities, adjusted by a percentage equal to 1 1/2 times the Inflation Factor computed under provisions of 471 NAC 31-008.06C5; or
3. 30 percent of the weighted mean for all ICF/MR facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C5. The mean will be weighted by the Nebraska Medicaid ICF/MR days.

31-008.06C3 ICF/MR Fixed Cost Component: This component of the prospective rate includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component of the prospective rate is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C4 ICF/MR Ancillary Cost Component: This component of the rate includes the ancillary cost center. The ancillary cost component of the prospective rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.065 ICF/MR Inflation Factor: This component of the rate is computed each Report Period from nursing facility cost reports required to be submitted under provisions of 471 NAC 12-011ff:

31-008.06C5a: From all reporting nursing facilities, facilities included in the computation are those that: 1) Did not have more than a 3% increase or decrease in occupancy from the previous Report Period, and 2) Maintained an occupancy level at 85% or greater (see 471 NAC 12-011.06B total Inpatient Days).

31-008.06C5b: Desk audited nursing facility cost reports for the current and the previous Report Period for the remaining facilities are used.

31-008.06C5c: Each nursing facility's average cost per day for each period is computed, adjusted for increases/decreases in case-mix acuity, and then compared to this computation from the previous Report Period. Percentage changes are arrayed from low to high.

31-008.06C5d: The Inflation Factor is the median percentage change, multiplied by 1.5 to adjust the Factor forward from the midpoint of the Reporting Period to the midpoint of the Rate Period. The Inflation Factor may not be less than "0%".

31-008.06C6 ICF/MR Prospective Rates for an Interim Year: Interim Year rates utilize each facility's prior Rate Period rate, increased by the Inflation Factor as computed per 471 NAC 31-008.06C5, except that the median is not increased by the 1.5 adjustment factor.

31-008.06C7 ICF/MR Exception Process: For Interim Years only, an individual facility may request, on an exception basis, the Director of HHS Finance and Support to consider specific facility circumstance(s), which warrant an exception to the computed Inflation Factor. An exception may only be requested if the facility's adjusted cost per day increase as computed in 471 NAC 31-008.06C5c is 2 percentage points or more than the median increase. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total cost increase to be 2 percentage points or more above the median increase, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operation; and
3. Preventive management action that was implemented to control past and future cause(s) of identified cost increases(s).

31-008.06D Rates for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF/MRs): The Department pays State-operated ICF/MRs an amount equivalent to the reasonable and adequate costs incurred during each report period.

An interim per diem rate is paid during the calendar year Rate Period, based on financial and statistical data as submitted by the ICF/MR for the most recent Reporting Period. The interim rate is settled retroactively to the facility's actual costs, which determine the Final Rate. The rate has four components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component; and
4. The Ancillary Cost Component.

The rate is the sum of the above four components. Rates cannot exceed the amount that can reasonably be estimated to have been paid under Medicare payment principles.

31-008.06D1 Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a calendar year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions, in accordance with provisions at 471 NAC 12-011.07A4 (Interim Rates for NF's).

31-008.06D2 Final Rate: The Department pays each ICF/MR a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

31-008.06D3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion shall consist of direct care staff, direct care administration, active treatment, and medical services. The support services portion shall consist of dietary, laundry, and housekeeping, property and plant, and administrative services.

Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR's most recent cost report period.

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers.

The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs.

The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/MR's most recent cost report period.

31-008.06E Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.06F Initial Rates for New Providers: Providers entering the NMAP as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering the NMAP as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR, will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

31-008.07 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the ICF/MR shall use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 1988 edition, to determine the useful life span. In the event that the ICF/MR determines a useful life shorter than a life shown in the tables, the facility shall have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 31-008.05J and 31-008.05K.

31-008.07A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

31-008.07B Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be –

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 31-008.05J and 31-008.05K);
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

31-008.07C Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Classification	Variable for Under 40 Beds	Basic Cost Bases For 40 to 75 Beds	Variable for Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

31-008.07D Recapture of Depreciation: Depreciation in 471 NAC 31-008.07D refers to real property only. An ICF/MR which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of –

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times \text{Sales Price} - \text{Book Value}$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:

	Data	
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4/2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

31-008.07E Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

31-008.07F Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

31-008.08 Reporting Requirements and Record Retention: Providers shall submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation shall prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct/reduce/eliminate data. Providers are notified of changes.

Each facility shall complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 15 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department shall suspend payment. At the time the suspension is imposed, the Department shall send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider shall maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All interim payments made during the rate period to which the cost report applies;
2. All interim payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets shall be retained for a minimum of five years after the assets are no longer in use by the provider. The Department shall retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than certified ICF/MR services shall report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility shall not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.